AGING WELL INC.

A Home for the Day
Adult Day Care Services
84 Social St.
Woonsocket, RI 02895
Phone: (401) 766-3734
Fax: (401) 765-5578

Thank you for your interest in our Adult Day care program. Attached is your application packet. Please return the completed application to us as soon as possible.

Your application packet includes:

- Applicant Information
- Financial Disclosure Form
- Authorization for Release of Medical Information

Please review, sign, and return all completed forms to A Home for the Day.
Thank you!

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APPLICANT INFORMATION

APPLICANT'S NAME: _____

FULL ADDRESS: _____

DATE OF BIRTH: _____

TELEPHONE: _____

ALLERGIES: YES _____ NO _____ (if yes, SPECIFY/REACTION):_____

SOCIAL SECURITY NUMBER: _____

*We will need a copy of your insurance and social security card for our confidential records.

WHO IS COMPLETING THIS APPLICATION? _____

RELATION TO APPLICANT: _____

CONTACT INFORMATION: (Please list primary caregiver first):

NAME	RELATION	ADDRESS	TELEPHONE	EMAIL

PRIMARY CARE PHYSICIAN: _____

TELEPHONE: _____ FAX:_____

ADDRESS: _____

OTHER PHYSICIAN(S) INVOLVED IN YOUR CARE: _____

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_____

_____

DECISION MAKING

Do you continue to make your own decisions and sign legal documents? _____

Do you have a power of attorney? YES_____NO_____
**If yes, we will need a copy for your medical record*

Do you have an advance directive? YES _____NO _____
If YES, we will need a copy for your medical record

If NO, are you interested in obtaining information regarding advance directives or a living will?
YES_____ NO_____

HELP US GET TO KNOW YOU

WHAT NAME WOULD YOU LIKE TO BE CALLED? _____

ARE YOU: Single_____ Married_____ Partner_____ Separated____

Divorced_____ Widowed_____

RACE (optional): Indian___ White___ Black/African American___ Hispanic___ Asian____

*PRIMARY LANGUAGE_____

SECONDARY LANGUAGE_____

RELIGIOUS/SPIRITUAL AFFILIATION: Protestant____ Roman Catholic_____ Jehovah Witness_____

Jewish____ Buddhist____ Hindu____ None _____ Other, please specify: _____

Do you have any cultural, spiritual or religious practices that we can support while you are attending our day program? _____

_____

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PLEASE LIST ANY ONGOING MEDICAL ISSUES:

WHAT IS THE APPLICANT'S/FAMILY'S GOAL FOR ADULT DAY CARE?

PLEASE LIST MEDICATIONS (* if to be given at "A Home for the Day" Adult Day Center):

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WHAT ARE YOUR INTERESTS AND EXAMPLES OF THINGS YOU ENJOY? What activities give you meaning outside of the setting, ie church, volunteering?

_____

_____

WHAT WAS YOUR TRADE OR OCCUPATION? _____

Were you in the armed forces? YES _____ NO _____COMMENT: _____

PHYSICAL NEEDS

Do you need to walk with someone close by? _____
Do you walk with a walker? _____ a cane? _____
Do you use a wheelchair? YES_____ NO _____
Is your vision impaired? YES _____ NO _____
Do you wear glasses? YES _____ NO _____
Do you wear dentures? YES _____ upper ___ lower___ NO_____
Is your hearing-impaired? YES_____ NO_____
Do you use a hearing aide? YES_____ left ____ right___ NO _____
Are you incontinent? BLADDER - YES_____ pads_____ briefs_____ NO_____
BOWEL - YES_____ NO _____
Do you have a colostomy, ileostomy or urostomy? YES ____ NO ____ If yes, specify_____

_____

Can you read in your primary language? YES _____ NO _____
Can you write? YES _____ NO _____

ACTIVITIES OF DAILY LIVING

Are you able to dress yourself? YES ____ NO_____
Are you able to shower / bathe yourself? YES ____ NO_____
Are you able to feed yourself? YES ____ NO_____SPECIAL DIET_____

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Do you smoke? YES ____ NO _____
Do you drink alcohol? YES ____ NO _____
Other? _____
Were you hospitalized in the last 3 months? _____If yes, why?
_____

DO YOU RECEIVE ASSISTANCE WITH ANY OF THE FOLLOWING?
**check all that are appropriate*

Meal preparation _____
Medication management _____
Shopping _____
Housekeeping _____
Paying bills _____

HOME SUPPORT/ SAFETY

What are your current living arrangements? _____
_____

Are there any safety concerns within the home? _____
_____
_____

Do you receive any home services? YES_____NO_____
IF YES, what services are you currently receiving?
**check all that apply:*

HOMEMAKER _____
NURSING ASSISTANT (C.N.A) _____
NURSING _____
PHYSICAL THERAPY _____
OTHER THERAPIES _____
NAME OF AGENCY _____
PHONE NUMBER OF AGENCY: _____

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ENROLLMENT

DAYS IS REQUESTED?

MON ____ TUE _____ WED ____ THUR _____ FRI _____

ARE YOU REQUESTING THAT WE ARRANGE FOR TRANSPORTATION?
YES_____ NO _____

*Requested AM pick-up time _____
*Requested PM drop-off time _____

TRANSPORTATION IS ARRANGED THROUGH MTM FOR ELDERS AND DISABLED ADULTS. THIS IS A DOOR TO DOOR SERVICE ONLY. IF THE APPLICANT IS NOT SAFE ALONE, THIS NEEDS TO BE SPECIFIED ON OUR REQUEST FOR TRANSPORTATION AND A REQUEST WILL BE MADE FOR A PERSON TO PERSON DROP OFF.
*Comment: _____
_____

IF A FAMILY MEMBER OR CAREGIVER WILL BE PROVIDING TRANSPORTATION, PLEASE PARK IN THE DAYCARE LOT (to the left of the building) AND SIGN YOUR LOVED ONE INTO OUR CARE EACH DAY THEY ARE SCHEDULED TO ATTEND.

_____ _____
DATE SIGNATURE

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FINANCIAL DISCLOSURE FORM

The financial information requested is essential in establishing a fee scale for Adult Care Services. You must complete this form in order to be considered for a reduced daily rate. I will need **Proof of Income**: a copy of tax return (if still filing), a copy of Social Security Beneficiary Award Letter, pension, annuities or IRA withdrawal schedule, interest income and other appropriate documents such as bank statements that will show all monthly income deposits otherwise, our full fee will be charged. All information is confidential and will not be disclosed.

***PLEASE provide MONTHLY NET INCOME for applicant and spouse*:**

	APPLICANT:	SPOUSE:
Salary	_____	_____
Social security	_____	_____
Pension	_____	_____
Rental property	_____	_____
Interest/Dividends	_____	_____
Disability	_____	_____
Other	_____	_____
TOTAL $	_____	_____

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OUR CURRENT SLIDING SCALE RATE AS OF 5/1/2021:

INDIVIDUAL	COUPLE	DAILY RATE
Up to $24,500	up to $33,000	$63
$24,501-34,299	$33,001- $45,199	$65
$34,000-38,199	$46,200 - $51,799	$70
$38,200 & over	$52,000 & over	$75

If your yearly income is less than $24,000 for individual or less than $32,400 for a couple, you may qualify for a cost share government subsidy program There is other criteria that need to be met to be considered for the program and needs to be re- applied for on an annual basis.
Income verification by will be required to be considered for sliding scale rate and cost share program.

I attest that the above financial information is true to the best of my knowledge:

Signature of applicant or representative

Date

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MEDICAL RELEASE

I, _____, grant permission to
(PATIENT or PATIENT REPRESENTATIVE)

Dr. _____ to release medical

Information pertaining to _____ to Aging Well, Inc.,
(PATIENT)

A Home for the Day Adult Day Care Center.

Patient Name: _____

Patient Date of Birth: _____

Patient's Address: _____

SIGNATURE OF PATIENT or PATIENT REPRESENTATIVE:

_____ Date: _____
(PATIENT or PATIENT REPRESENTATIVE)

IF PATIENT REPRESENTATIVE:

Relationship to patient: _____

Patient Representative's Address: _____

Patient Representative Phone: _____